



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

LONE STAR BONE & JOINT CLINIC

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-08-1766-01

Carrier Austin Representative

Box Number 54

MFDR Date Received

November 9, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Separate procedure. Different day separate procedure."

Amount in Dispute: \$ 5,212.16

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor, for its part, has not submitted any information whatsoever to support its position other than its assertion that all the codes represent separate procedures and should be paid as such... No further payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 12, 2007	99222-57	\$168.64	\$14.09
May 12, 2007	28485	\$1431.31	\$51.02
May 12, 2007	11012	\$1090.90	\$25.17
May 15, 2007	28485-78	\$1431.31	\$51.02
May 15 2007	11012-78	\$1090.00	\$25.17
TOTAL		\$5,212.16	\$166.47

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.202 sets out the medical fee guidelines or professional services provided between August 1, 2003 and March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- CAC W1 – Workers Compensation rate fee schedule adjustment.
- CAC 45 – Charges exceed your contracted/legislated fee arrangement.
- CAC 59 – Charges are adjusted based on the multiple surgery rules or concurrent anesthesia rules.
- 102 – DWC has indicated that an exception is granted and an allowance is authorized.
- 329 – Allowance for this service represents 50% because of the multiple or bilateral rules.
- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
- Note: Payment is allowed per the maximum allowable reimbursement (MAR) or the allowed amount per trailblazer. Not the amount the provider bills. Payment has been allowed correctly per MAR.
- 878 – Duplicate.
- CAC W4 – No additional reimbursement allowed after review of appeal/reconsideration.
- 891 – The insurance company is reducing or denying payment after reconsideration.

Issues

1. Was the workers' compensation insurance carrier entitled to pay the health care provider at a contracted rate?
2. Did the requestor bill in conflict with the NCCI edits?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced disputed services with reason code "45 Charges exceed your contracted/legislated fee arrangement." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on January 13, 2011 the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. The insurance carrier did not submit documentation to support notification to the healthcare provider in the time and manner required. The Division concludes that pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. Per 28 Texas Administrative Code §134.202 "(b) (b) For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section."

The division completed NCCI edits to identify edit conflicts that may affect reimbursement. The following was identified:

The requestor billed CPT codes 99222, 28485 and 11012 on May 12, 2007. No NCCI edits conflicts were identified. Therefore the disputed charges will be reviewed pursuant to 28 Texas Administrative Code §134.203 (c).

The requestor billed CPT codes 28485-78 and 11012-78 on May 15, 2007. No NCCI edits conflicts were identified. Therefore the disputed charges will be reviewed pursuant to 28 Texas Administrative Code §134.203 (c).

3. Per 28 Texas Administrative Code §134.202 "(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%. For Anesthesiology services, the same conversion factor shall be used."
- Date of service May 12, 2007. The requestor billed CPT code 99222. Per CMS the CPT code 99222 contains a "0" multiple procedure rule indicator, therefore the disputed charge is not subject to the multiple procedure rule. The CMS reimbursement for CPT code 99222 is $\$133.16 \times 125\% = \166.45 . The insurance carrier issued a payment in the amount of \$152.36. The requestor is therefore entitled to an additional reimbursement in the amount of \$14.09.

Date of service May 12, 2007. The requestor billed CPT codes 28485 and 11012. Per CMS the CPT code 28485 and 11012 contain a multiple procedure indicate of "2". The CMS defines the "2" indicator as "2 = Standard payment adjustment rules for multiple procedures apply. If the procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 50 percent, 50 percent, 50 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage.

The CMS reimbursement for CPT code 28485 is $\$482.17 \times 125\% = \602.71 , reimbursed at 100%, for a MAR amount of \$602.71. The insurance carrier paid \$551.69. The requestor is therefore entitled to an additional reimbursement in the amount of \$51.02.

The CMS reimbursement for CPT code 11012 is $\$475.63 \times 125\% = \594.54 , reimbursed at 50%, for a MAR amount of \$297.27. The insurance carrier paid \$272.10. The requestor is therefore entitled to an additional reimbursement in the amount of \$25.17.

Date of service May 15, 2007. The requestor billed CPT codes 28485 and 11012. Per CMS the CPT code 28485 and 11012 contain a multiple procedure indicate of "2". The CMS defines the "2" indicator as "2 = Standard payment adjustment rules for multiple procedures apply. If the procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 50 percent, 50 percent, 50 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage.

The CMS reimbursement for CPT code 28485 is $\$482.17 \times 125\% = \602.71 , reimbursed at 100%, for a MAR amount of \$602.71. The insurance carrier paid \$551.69. The requestor is therefore entitled to an additional reimbursement in the amount of \$51.02.

The CMS reimbursement for CPT code 11012 is $\$475.63 \times 125\% = \594.54 , reimbursed at 50%, for a MAR amount of \$297.27. The insurance carrier paid \$272.10. The requestor is therefore entitled to an additional reimbursement in the amount of \$25.17.

4. Review of the submitted documentation finds that the requestor is entitled to additional reimbursement in the amount of \$166.47. Therefore, this amount is recommended for date of service May 12, 2007 and May 15, 2007.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$166.47.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$166.47 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

April 1, 2014
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a *certificate of service demonstrating that the request has been sent to the other party.***

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.